APOLOGETIC TORT THINK: AUTONOMY AND INFORMATION TORTS

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I. INTRODUCTION

IT is difficult to imagine a presentation on the subject of research and experimentation or, *a fortiori,* consent, that fails to pay homage to the history and structure of the tort law doctrine of informed consent. Any torts lawyer in attendance would be captivated by the possibility of linkage between the tort doctrine of informed consent and the self-determination/autonomy debate. However, caution should be exercised before pressing that linkage too far. When bio-ethicists discuss consent they relate it to autonomy. In contrast, the tort doctrine of informed consent is dominated by allocational rationales and structures. Caution is necessary lest informed consent escape from its footnote status to deflect bio-ethicists and the autonomy debate into far shallower waters.

Now, this is hardly new territory. Professor Katz, that champion of self-determination, has been less than enthused by the current state of informed consent law.[1] Indeed, Katz, writing in 1984, made his dissatisfaction evident by noting that the common law doctrine of informed consent "has secured for patients the right to better custody but not to liberty."[2]

If anything, Katz's position is somewhat generous. A more extreme critique might challenge whether the doctrine of informed consent as we know it today has *any* relevance to the modern bio-ethical debate on autonomy. At the very least, it may be argued that tort law has made little progress since the "converted battery" cases of the 1960s and 1970s,[3] and has been noticeably

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1. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 48-84 (1984) [hereinafter SILENT WORLD]. *See also* Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977).

2. SILENT WORLD, *supra* note 1, at 49.

3. Converted battery cases are those transitional cases in which the courts moved the battery (with vitiated consent) cause of action into negligence. *See* Cobbs v. Grant, 502 P.2d 1, 7 (Cal. 1972); Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972). *Cf.* Mohr v. Williams, 104 N.W. 12, 16 (1905) (physician performing operation on patient's left ear liable for battery when patient only consented to surgery on right ear); *see also infra* notes 6, 9 and accompanying text.

deficient in developing any coherent body of law regulating and improving the flow of information between parties who suffer radically disparate information costs. Such a hypothesis references three arguments. First, Katz's basic critique of informed consent is re-emphasized. Second, the inability of torts lawyers to separate the "informed" aspect of the doctrine from the "consent" aspect is viewed as an important obstacle in the development of the information torts. Third, note is taken of the unease with which tort doctrine has addressed the related area of wrongful life, an area in which the converted battery paradigm seems particularly inappropriate.

II. INFORMED CONSENT CASES

With the exception of Professor Katz,[4] just about every other historian of informed consent has paid extravagant homage to Judge Cardozo's opinion in *Schloendorff v. Society of N. Y. Hospital*.[5] In *Schloendorff* Cardozo apparently cemented the link between tort law doctrine and autonomy with his comment that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."[6]

For Katz, however, the subsequent developments of the informed consent doctrine are distinguished by retreat: "[J]udges have made impassioned pleas for patient self-determination, and then have undercut them by giving physicians considerable latitude to practice according to their own lights . . . ."[7] Much of the discussion by Katz focuses on the doctrine's primary operational rule of adequacy and the question whether to use a "need-to-know" patient-oriented standard or a physician-sourced, custom-based standard of disclosure. Katz's critique was and remains sound.[8] However, the challenge may be made on more fundamental grounds.

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4. SILENT WORLD, *supra* note 1, at 51-52.

5. 105 N.E. 92 (N.Y. 1914).

6. *Id.* at 93.

7. SILENT WORLD, *supra* note 1, at 49.

8. See, e.g., the discussion in Largey v. Rothman, 540 A.2d 504 (N.J. 1988), and the conclusion that:

> Perhaps the strongest consideration that influences our decision in favor of the "prudent patient" standard lies in the notion that the physician's duty of disclosure "arises from phenomena apart from medical custom and practice": the patient's right of self-determination. The foundation for the physician's duty to disclose in the first place is found in the idea that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie." In contrast the arguments for the "professional" standard smack of an anachronistic paternalism that is at odds with any strong conception of a patient's right of self-determination.

Id. at 509 (citations omitted).

For example, it is arguable that informed consent was adopted not out of any sense that it would better promote autonomy, but because of essentially internal tort structure concerns that the tort of battery was being distorted.[9] Looking back it is now tempting to inquire whether autonomy, as it was voiced in those early cases,[10] was put forward as the genuine rationale for the new doctrine of informed consent, or whether it was merely a convenient notion—an attractive philosophical and ethical symbol or benchmark at which to nod in passing.

Of course, there can be no disagreement with Katz's observations concerning the continuing contemporary retreat from any informed consent which would fully promote self-determination, a retreat evidenced by the passage of state legislation tending to adopt the less rigorous custom rule for judging adequacy of risk disclosure.[11] Involving informed consent doctrine in medical malpractice "crisis" legislation reflects a physician and hospital mentality focusing on the minimum required or bottom line to avoid liability—in contrast to the more attractive and enlightened goals noted by Katz.[12] Indeed, it is important to see how "tort think" has distorted the growth of informed consent and demoted it into just another issue in the panoply of risk management.

In tort law, the symbolic appeal to self-determination has long been forgotten. In its stead, torts lawyers have developed a far less inspiring decisional tree. First, they inquire, is this a "no-consent" case or a "lack of informed consent" case? Second, if it is of the latter species, torts lawyers pose the jurisdiction-sensitive question of whether a patient standard or a physician standard should be applied in measuring the appropriate level of disclosure.

The answer to the first question determines whether the case will be brought in intentional tort or negligence. If it is a "no-consent" case, the

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9. *See, e.g.*, Cobbs v. Grant, 502 P.2d 1, 8 (Cal. 1972):

> The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.

Cf. Mink v. Univ. of Chicago, 460 F. Supp. 713, 717 (N.D. Ill. 1978) (battery action where plaintiffs not told they were part of an experiment).

10. Most are discussed by Katz. *See* SILENT WORLD, *supra* note 1, at 60-80.

11. *Id.* at 81-82.

12. *See, e.g., id.* at 83-84 (these goals include doctor-patient interaction in the decision making process, focusing on process and self-determination).

former battery applies; if it is a "lack of informed consent" case, negligence applies as the regulatory mechanism.[13] But why do torts lawyers make this distinction? One thing is sure: autonomy considerations are not involved. According to a representative Wisconsin court, the reasons why battery doctrine is not applicable to "lack of informed consent" cases include the following:

> First, the act complained of in these cases simply does not fit comfortably within the traditional concepts of battery—the intent to unlawfully touch the person of another. In cases such as the instant one, physicians are invariably acting in good faith and for the benefit of the patient . . . . Second, . . . the failure to inform a patient is probably not, in the usual case, an intentional act and hence not within the traditional concept of intentional torts. Third, the act complained of in informed consent cases is not within the traditional idea of "contact" or "touching." In the typical situation, as here, the physician impeccably performs the surgery or other treatment . . . . Fourth, a valid question exists with respect to whether a physician's malpractice insurance covers liability for an arguably criminal act—battery. If not, it may be asked why a physician should be required to pay out of his own pocket for what is essentially an act of negligence—failing to inform a patient of the risks indigenous to the treatment? Fifth, these essentially negligence cases do not fit the traditional mold of situations wherein punitive damages can be awarded.[14]

This meta-doctrinal laundry list is important not for what it says but for what it omits. Where, for example, are the concerns about competing goals of medical professionalism and autonomy? The answer is that they are simply not reflected here. Rather, these criteria disclose a decisional system dominated by allocational and structural concerns.

On to the second question: If we have an informed consent case, are we going to apply a patient standard or a physician standard? So stated, we appear to have identified the torts analog to the core of the bio-ethical debate.[15] But does this analog truly possess the same content? The dominant purpose in the torts debate is to come up with the operational rule most suited to the degree of loss reallocation that a court wishes to adopt[16]—it lacks or minimizes the ethical component in the bio-ethicists' consent debate. While bio-ethicists examine the intrinsics of the competing standards of disclosure,

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13. A battery cause of action is available when the physician fails to disclose to the patient the nature and character of the operation to be performed, in that the patient's consent under such circumstances is invalid; a negligent nondisclosure action is available when the patient is apprised of the nature of the operation but the physician fails to explain the risks of the procedure. Kohoutek v. Hafner, 383 N.W.2d 295, 298-99 (Minn. 1986).

14. Trogun v. Fruchtman, 207 N.W.2d 297, 313 (Wis. 1973) (footnotes omitted).

15. Jay Katz, *Human Experimentation and Human Rights*, 38 ST. LOUIS U. L.J. 7 (1993).

16. *See generally* Nicolas P. Terry, *Collapsing Torts*, 25 CONN. L. REV. 717, 718-22 (1993).

torts lawyers use them as little more than conclusory labels applied to allocational models.

III. INFORMED CONSENT AND INFORMATION TORTS

The further we move away from the paradigm informed consent case the clearer it becomes that informed consent has failed to shed its battery antecedents. Rather, we see demonstrated a lackluster progress toward any recognition of a duty to inform and disclose operating *outside of* the context of consent to an intrusive procedure.

As such, an exceptional case is the California opinion of *Truman v. Thomas*.[17] There, the plaintiff's decedent consulted the defendant physician during a six-year period. Allegedly, the defendant failed to inform her of the risks of *not* having a pap smear test. Subsequently, the patient died of cervical cancer at the age of thirty. The doctor argued that he had been under no duty to disclose, because that duty applies "only where the patient *consents* to the recommended procedure,"[18] and that "patients who reject their physician's advice should shoulder the burden of inquiry as to the possible consequences of their decision."[19] Rejecting that argument the court noted:

> The duty to disclose was imposed . . . so that patients might meaningfully exercise their right to make decisions about their own bodies. The importance of this right should not be diminished by the manner in which it is exercised. Further, the need for disclosure is not lessened because patients reject a recommended procedure. Such a decision does not alter "what has been termed the 'fiducial qualities' of the physician-patient relationship," since patients who reject a procedure are as unskilled in the medical sciences as those who consent . . . . It must be remembered that Dr. Thomas was not engaged in an arms-length transaction with Mrs. Truman. Clearly . . . he was obliged to provide her with all the information material to her decision.[20]

However, *Truman* remains a lonely voice. Far more typical are discouraging pronouncements from torts judges to the effect that the doctrine of informed consent applies only to surgical procedures and "has not been extended to therapeutic treatment, which is usually an ongoing treatment upon examination by the treating physician, where any change of condition can be diagnosed and controlled."[21]

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17. 611 P.2d 902 (Cal. 1980).

18. *Id.* (emphasis added).

19. *Id.*

20. *Id.* (citations omitted).

21. Malloy v. Shanahan, 421 A.2d 803, 804 (Pa. Super. Ct. 1980). *See also*, Pratt v. University of Minn. Affiliated Hosps. & Clinics, 414 N.W.2d 399, 402 (Minn. 1987) (no duty to inform patient that diagnosis may be incorrect).

Consistent with this approach is the recent California Supreme Court case of *Arato v. Avedon*.[22] There, the court held that a physician is not required in every case to disclose the patient's statistical life expectancy.[23] "Rather than mandate the disclosure of specific information as a matter of law, the better rule is to instruct the jury that a physician is under a legal duty to disclose to the patient all material information . . . needed to make an informed decision regarding a proposed treatment."[24]

The *Arato* court also held that the duty of disclosure involves information related to the patient's medical decision making and not to such matters as estate planning. The plaintiff asserted that the patient would have ordered his business affairs accordingly if he had known of his imminent demise.[25] The court replied that "[t]he short answer to plaintiffs' claim is . . . that a 'physician is not the patient's financial adviser.'"[26]

Surely, however, if we are truly to shed light on Professor Katz's "silent world" it should be through a more vigorous—indeed, as Katz himself puts it, "punctilious"—promotion of the flow of information in *all* situations. That is, tort law should earnestly be promoting such actions, not viewing them with suspicion. Unfortunately, the failure of the courts to fashion a comprehensive vision of information flow, to conceptualize the "information tort," has condemned informed consent doctrine to merely affecting the quality of "custody" and has done nothing for "liberty."[27]

IV. IMPAIRED LIFE CASES

If the courts have been hesitant to move from informed *consent* to lack of *information*, they have exhibited even more unease the further plaintiffs ask them to stray from the paradigm. A good example is the sub-set of prenatal injury fact-patterns that frequently are referred to as wrongful or impaired life cases.[28] The typical situation is where a prenatal test allegedly would have

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22. 858 P.2d 598 (Cal. 1993).

23. *Id.* at 140. The plaintiff's decedent in *Arato* was the victim of a particularly deadly form of cancer, and the treatment undertaken by the defendant physicians was experimental, painful, and of speculative curative value. *Id.* at 134. The plaintiff asserted that her husband would not have undergone the treatment, but would instead have lived out his final days in comfort in the bosom of his family, if he had known that his statistical life expectancy and the chances for the therapy's success were both very limited. *Id.* at 135.

24. *Id.* at 140.

25. *Id.* at 141-42 (no duty to disclose every contingency that might affect the patient's nonmedical rights and interests).

26. *Id.* at 141 (quoting Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 n.10 (1990)).

27. SILENT WORLD, *supra* note 1, at 49.

28. There is no little confusion concerning the terminology in these prenatal injury cases. As a result we have suggested the following:

(i) *Wrongful Life:* An action brought by the child complaining of her social or financial status in life or her very existence.

diagnosed a genetic disorder presumably leading to a decision whether or not to terminate the pregnancy. Generally speaking, courts have rushed into the arms of no-duty language, and refused a child later born with such a genetic defect any substantial recourse against an admittedly negligent doctor or genetic testing laboratory.

The court's seeming unease in dealing with information torts and the linkage between informed consent and impaired life can be illustrated by reference to two cases: the first an under-appreciated informed consent case; the latter a leading impaired life case.

In *Shack v. Holland*[29] plaintiffs—mother and son—claimed that as a result of the defendant's negligent conduct and a lack of informed consent, the son was born maimed and deformed. Realizing that it was dealing with the confluence of informed consent and prenatal tort the court stated:

> [T]he issues presented are whether a conditional prospective liability to a fetus is created when an unborn child's mother is not sufficiently informed of the risks, hazards and alternatives of the delivery procedure administered, and whether such liability attaches upon the birth of the child and [enures] to the benefit of the child in the nature of a cause of action for the lack of informed consent.[30]

For the court, and given the developments in prenatal tort recovery for negligence, the real question was whether that right may be extended to include an action for lack of informed consent.[31] With minimal discussion the court framed and resolved the issue as follows:

> The court finds that although the obligation to disclose runs to the mother, plaintiff . . . then unborn but within his mother's womb, comes within the area of persons to be protected. The lack of informed consent of the mother would have its effect upon the fetus to be born for good or ill. A child in its mother's womb is a foreseeable circumstance. Conduct, which creates a risk of harm to a woman, includes also a risk of harm to her unborn child. The standard of care imposed upon the doctor by the statute [enures] to the benefit of her unborn child. This is a classic example of derivative liability whereby

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(ii) *Impaired Life:* An action brought by the child complaining that she suffers from a physical impairment which, while not caused by the defendant, should have been anticipated by the defendant prior to her conception or birth.

(iii) *Wrongful Birth:* An action brought by a parent complaining that her child suffers from an impairment which, while not caused by, should have been anticipated by the defendant prior to the child's conception or birth.

(iv) *Wrongful Pregnancy:* An action brought by a parent complaining that her child would not have been conceived or born but for the negligence of the defendant.

J.J. PHILLIPS ET AL., CASES, MATERIALS AND PROBLEMS IN THE LAW OF TORTS 522 (1991).

29. 389 N.Y.S.2d 988 (N.Y. Sup. Ct. 1976).

30. *Id.* at 989.

31. *Id.* at 991.

> a plaintiff may institute an action to redress a wrong done to himself which is proximately caused by a wrong done to another.[32]

In holding that a child may bring a postnatal wrongful life action for breach of the duty to obtain informed consent when adequate information had not been conveyed prenatally to his mother, the court set a path for recognizing the necessity for increasing the flow of information between doctor and patient well beyond the paradigm. Unfortunately, this opinion did not promote the further development of the doctrine; a fault that lies not so much in *Shack* itself, but in the opinions in subsequent wrongful birth and wrongful life cases that failed to make the conceptual link between the fact patterns.

To an extent that link *was* made by the Supreme Court of California in *Turpin v. Sortini*,[33] though the court failed to exploit it to the full. Hope Turpin was examined by the defendant, a specialist in the diagnosis of speech and hearing defects. She was diagnosed as having normal hearing although, in fact, she was deaf because of a hereditary ailment. After the allegedly negligent diagnosis, but prior to learning of Hope's deafness, the Turpins conceived a second child who subsequently was born suffering from the same hereditary deafness. The Turpins alleged that they would not have had the second child if they had known of the risk of the hereditary ailment before the child's conception. The court was relatively untroubled by the parents' cause of action for wrongful birth,[34] noting that "[t]he overwhelming majority of recent cases have permitted parents to recover at least some elements of damage in such actions."[35]

However, the court was more hesitant regarding the allegation of wrongful life by the Turpins' second child. Prior courts disapproving of such a cause of action had cited two primary reasons for disallowing recovery: a conclusory view that the child had suffered no "legally cognizable injury," and the difficulty/impossibility of ascertaining damages in such cases.[36]

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32. *Id.* at 993.

33. 643 P.2d 954 (Cal. 1982).

34. *See supra* note 28 (defining wrongful birth).

35. *Turpin*, 643 P.2d at 957. *Cf.* Wilson v. Kuenzi, 751 S.W.2d 741, 744-45 (Mo. 1988) (en banc), denying the parents' claim and stating:

> A reading of all of the cases persuades us that the real underlying problem in these cases stems from the fact that the courts have either closed their eyes to traditional tort causation, or have leaped over causation . . . .
>
> The heart of the problem in these cases is that the physician cannot be said to have caused the defect. The disorder is genetic and not the result of any injury negligently inflicted by the doctor. In addition it is incurable and was incurable from the moment of conception. Thus the doctor's alleged negligent failure to detect it during prenatal examination cannot be considered a cause of the condition by analogy to those cases in which the doctor has failed to make a timely diagnosis of a curable disease. The child's handicap is an inexorable result of conception and birth.

36. *See, e.g.*, Becker v. Schwartz, 386 N.E.2d 807 (N.Y. 1978).

In discussing the child's cause of action, there can be little doubt that the California Supreme Court viewed information flow as at the root of the issue. Indeed, the court volunteered the answer to one of the logical problems inherent in the fact pattern—how can the fetus be supplied with information—when it stated:

> Of course, in the wrongful life context, the unborn child cannot personally make any choice as to the relative value of life or death. At that stage, however, just as in the case of an infant after birth, the law generally accords the parents the right to act to protect the child's interests. As the wrongful birth decisions recognize, *when a doctor or other medical care provider negligently fails to diagnose an hereditary problem, parents are deprived of the opportunity to make an informed and meaningful decision* whether to conceive and bear a handicapped child . . . . Although in deciding whether or not to bear such a child parents may properly, and undoubtedly do, take into account their own interests, parents also presumptively consider the interests of their future child. Thus, *when a defendant negligently fails to diagnose an hereditary ailment, he harms the potential child as well as the parents by depriving the parents of information* which may be necessary to determine whether it is in the child's own interest to be born with defects or not to be born at all.[37]

Notwithstanding, the *Turpin* court ultimately denied recovery on the basis that there was no rational means for the jury to assess damages for pain and suffering, or for the difference between the plaintiff's condition and what it would have been in the absence of negligence.

In so doing, the court rejected the view of an intermediate appellate court that would simply reference the plaintiff's condition after birth.[38] The court summarized its disagreement as follows:

> [I]n fixing damages in a tort case the jury generally compares the condition plaintiff would have been in but for the tort, with the position the plaintiff is in now, compensating the plaintiff for what has been lost as a result of the wrong. Although the valuation of pain and suffering or emotional distress in terms of dollars and cents is unquestionably difficult in an ordinary personal injury action, jurors at least have some frame of reference in their own general experience to appreciate what the plaintiff has lost—normal life without pain and suffering. In a wrongful life action that simply is not the case, for what the plaintiff has "lost" is not life without pain and suffering but rather the unknowable status of never having been born. In this context, a rational, nonspeculative determination of a specific monetary award in accordance with normal tort principles appears to be outside the realm of human competence.[39]

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37. *Turpin*, 643 P.2d at 962 (emphasis added) (citations omitted).
38. Curlender v. Bio-Science Laboratories, 165 Cal. Rptr. 477 (Cal. Ct. App. 1980).
39. *Turpin*, 643 P.2d at 964.

Compare the traditional intrusive procedure-type informed consent case. Is not the same damage assessment issue present? Courts seem sanguine about allowing the jury to compare the condition of the patient (now suffering from the non-informed and incurred risk) with the patient as she was prior to the procedure despite of uncertainty as to what would have happened absent the procedure.[40] Why are such approximations outside the competence of juries in the conceptually similar impaired life cases?

Of course, judicial reticence in impaired life cases may be explainable on the basis they have become embroiled in the abortion debate.[41] However, it is at least arguable that, once again, the further our courts move away from the battery paradigm, the less satisfactorily they deal with the questions of information flow, real consent, and real autonomy. The tentative conclusion is that while courts may have said that they were retiring the law of battery, that retirement has been strictly symbolic.

V. CONCLUSION

Torts lawyers and the judicial authors of the seminal informed consent cases continue to be flattered by their inclusion in the autonomy debate. However, they should be confined to the most historical of footnotes lest too much be made of informed consent, reading into it a philosophical and ethical content that, today, is simply not there.

Obviously, it does not follow that the doctrine of informed consent *should not* have a fully developed ethical structure, merely that it *does not*. Even if bio-ethicists have little to gain from examining contemporary tort law, it does not follow that torts lawyers will not gain from taking up a more enlightened notion of informed consent. Indeed, attempting to inject a pervasive sense of autonomy into "tort think" might provide some of the over-arching conceptual bridges to developing a more sophisticated view of information torts.

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40. This issue is what one references to begin the *restitution in integrum* quantification calculation. It is distinct from the question whether the patient would still have undertaken the procedure if she *had been informed of the risks. See, e.g.*, Arena v. Gingrich, 748 P.2d 547 (Or. 1988); Cheung v. Cunningham, 520 A.2d 832 (N.J. Super. Ct. App. Div. 1987).

41. *See, e.g.*, 42 PA. CONS. STAT. ANN. § 8305 (Purdon Supp. 1989).